Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOCTOR'S HOSPITAL OF LAREDO 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-08-6605-01 DWC Claim #: Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility $12,354.88 for DRG #0496. A Medicare pricer-print out has also been attached for your review. Medicare would have allowed the provider 140% of the allowable which would be $17,667.48. Based on their payment, a supplemental payment is due."

Amount in Dispute: $13,661.72

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Authorization was given for an out-patient stay for left shoulder arthroscopy. (Exhibit 1) The HCP billed for a one day IN-patient hospital stay. In good faith, Texas Mutual reimbursed the requester based on its billing and allowed a one day surgical per diem of $1,118.00. Texas Mutual also paid a fair and reasonable reimbursement for the implants. The requestor did not submit a copy of the invoices from the supplier. Texas Mutual considers the payment made to be fair and reasonable."

Response Submitted by: Linda Estrada, 6210 East Hwy 290, Austin, TX 78723

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/26/2007 through 10/27/2007	CAC-16, 225, CAC-W4, 891, 895, CAC-W1, CAC-W10, CAC-143, CAC-97, 420, 480, 719, 730, CAC-150, 890	Inpatient Surgery	$13,661.72	$269.24
			Total Due:	$269.24

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):
   - CAC-16- Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 891-The insurance company is reducing or denying payment after reconsideration.

- 895-In order to analyze the attached billing we will need a copy of the itemized billing.
- CAC- W1-Workers Compensation state fee schedule adjustment.
- CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-143-Portion of payment deferred.
- CAC-97-Payment is included in the allowance for another service/procedure.
- CAC-97-Payment adjusted because the benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated. This change to be effective 4/1/2008 the be. [sic]
- 420-Supplemental payment.
- 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guidelines.
- 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
- 730-Denied as included in per diem rate.
- CAC-150-Payment adjusted because the payer deems the information submitted does not support this level of service. This change to be effective 4/1/2008: Payer deems the information submitted does not support.
- 890-This level of service is being disputed as it does not meet the components as defined in the "CPT Book."

2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401.
3. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." A review of the submitted medical bill and itemized statement, indicate that the requestor billed for one (1) inpatient surgical day; therefore, this admission meets the definition of inpatient services per Division rule at 28 TAC §134.401(b)(1)(B).
4. A review of the submitted hospital bill supports operating room services; therefore, the Division finds that this is a surgical admission.
5. Division rule at 28 TAC §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."
6. The hospital admission was from 10/26/2007 through 10/27/2007; therefore, the length of stay was one day.
7. Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 X $1118.00 = $1,118.00.
8. Division rule at 28 TAC §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
9. Division rule at 28 TAC §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278)." The Division finds that on the medical bill the requestor billed for seven (7) implants. The operative report states "…three of the Anthrex 5.5 millimeter Bio-Cork screw FT suture anchors with…three PEEK push locks." The requestor submitted the implant invoice that supports the following:

Implant	Cost	Quantity	Cost + 10%
Bio-Cork Screw 5.5mm	$450.00	3	$450.00 X 3 = $1,350.00 + 10% = $1,485.00
PEEK push locks	$460.00	3	$460.00 X 3 = $1,380.00 + 10% = $1,518.00
Suture Lasso (Hook Angled)	$140.00	1	$140.00 + 10% = $154.00
TOTAL		7	$3,157.00

10. Per Division Rule at 28 TAC §134.401, the total reimbursement due the requestor for this admission is $1,118.00 + $3,157.00 = $4,275.00. The respondent paid $4,005.76. The difference between the amount due and paid is $269.24.

As a result of this review, the requestor is due additional reimbursement of $269.24.

11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor is due additional reimbursement per Division Rule at 28 TAC §134.401. As a result, the amount ordered is $269.24.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $269.24 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	**5/11/2011** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.